



Communicable Disease Branch Coronavirus Disease (COVID-19) Weekly Key Points

December 15, 2020

The North Carolina Division of Public Health (NC DPH) Communicable Disease Branch will be releasing COVID-19 weekly key points that includes information discussed on the weekly Tuesday Local Health Department call. Recordings of the call will not be made available; please use the information below as a summary of the topics presented on the call. As guidance changes, please use the most recent information provided. For questions, contact the NC DPH Communicable Disease Branch 24/7 Epidemiologist on Call at **919-733-3419**.

Important Updates

- **New:** NCDHHS_LHD Weekly Webinar_12.15.2020.pdf (file attached)
- **New:** COVID-19 Death Reporting in NC COVID 12-20.pdf (file attached)
- **Updated:** Local Health Vaccine FAQ-Final 12.11.20.pdf (file attached)
- **Updated:** Find My Testing Place (file attached)

Infection Prevention Updates, Including Antigen Testing in Long-Term Facilities

Clarification of Testing in LTCFs (14 vs 28 days)

- We adhere to CMS and CDC criteria of 14 days in LTCFs when considering testing and visitation.
- Facilities should conduct routine staff testing based on the county / community positivity rate.
- At the time that facilities are identified to have an outbreak, facilities should conduct outbreak testing until they have gone 14 days without a new case identified. During this time, positive rapid antigen tests do not need to be confirmed with a PCR.
- Once 14 days have passed, from days 15-28 (2 incubation periods), facilities should conduct routine staff testing and testing of symptomatic persons. During this timeframe, facilities should follow the 'facility without an outbreak' arm in the [CDC algorithm for interpretation of antigen test results in nursing homes](#), and if a resident or staff member tests positive on a rapid antigen test, a confirmatory PCR test should be conducted.
- Do not close a NCEDSS facility outbreak event until a facility has gone 28 days without a case.
- Facilities will remain on the NC DHHS Outbreak list for 28 days.

Alternative options for quarantine: Are the alternatives to the 14-day quarantine described in the [Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing](#) recommended for healthcare facilities?

- We strongly recommend that a 14-day quarantine period be implemented both for healthcare providers and patients/residents.
- Healthcare facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages but this is not a preferred option.



- Individuals who do follow an alternative option for quarantine should continue to monitor for and immediately self-isolate if symptoms occur during the 14 days after their exposure and adhere to all recommended [non-pharmaceutical interventions](#).

CDC Post-Vaccination IPC Considerations Guidance for [Healthcare Personnel](#) & [Residents of LTCFs](#)

Fever, fatigue, headache, chills, myalgia, and arthralgia can occur following COVID-19 vaccination. Preliminary data indicate that most symptoms are mild to moderate in severity, occur within the first three days of vaccination, resolve within 1-2 days of onset, and are more frequent and severe following the second dose and among younger persons compared to those who are older (>55 years).

Cough, shortness of breath, rhinorrhea, sore throat, or loss of taste or smell are **not** consistent with post-vaccination symptoms, and instead may be symptoms of SARS-CoV-2 or another infection.

Healthcare Personnel:

Until more is known, vaccinated HCP should continue to follow all [current infection prevention and control recommendations](#). This includes use of all PPE for the care of patients or residents requiring transmission-based precautions, and adhering to universal facemask and eye protection, physical distancing, and hand hygiene.

Strategies to minimize **the impact of post-vaccination systemic signs and symptoms on healthcare staffing and limit unnecessary work restrictions include:**

- Vaccinating HCP preceding 1-2 days off.
- Staggering delivery of vaccine to HCP in the facility so that not all HCP in a single department, service, or unit are vaccinated at the same time.
- Informing HCP about the potential for short-term signs and symptoms post-vaccination and use of nonsteroidal anti-inflammatory medications or acetaminophen.
- Provide timely assessment of HCP with signs and symptoms post-vaccination, including providing or identifying options for SARS-CoV-2 viral testing.
- Offering nonpunitive sick leave options (e.g., paid sick leave) for HCP remove barriers to reporting symptoms.

Suggested approaches to evaluating and managing new-onset systemic post-vaccination signs and symptoms in HCP:

Positive viral tests for SARS-CoV-2, if performed, should **not** be attributed to the COVID-19 vaccine, as vaccination does not influence the results of these tests. For symptomatic HCP who have received COVID-19 vaccination in the prior 3 days (including day of vaccination, which is considered day 1) and are not known to have had unprotected exposure to SARS-CoV-2 in a [community](#) or [healthcare](#) setting in the previous 14 days:

- **Exclude HCP from work pending evaluation** for possible etiologies, including SARS-CoV-2 infection, as appropriate.
- HCP with fever should be excluded from work pending further evaluation, including consideration for SARS-CoV-2 testing.

Follow return to work criteria for the suspected or confirmed diagnosis. Information on return to work for HCP with SARS-CoV-2 infection is available [here](#). If symptomatic HCP return to work, they should be advised to



contact occupational health services (or another designated individual) if symptoms are not improving or persist for more than 2 days. Pending further evaluation, they should be excluded from work and viral testing should be considered. If performed, a negative [SARS-CoV-2 antigen test](#) in HCP who have signs and symptoms that are not typical for post-vaccination signs and symptoms should be confirmed by SARS-CoV-2 nucleic acid amplification test (NAAT).

*In facilities where critical staffing shortages are anticipated or occurring, HCP with fever and systemic signs and symptoms limited **only** to those observed following vaccination could be considered for work if they feel well enough and are willing. These HCP should be re-evaluated, and viral testing for SARS-CoV-2 considered, if fever does not resolve within 2 days.*

LTCF Residents:

For symptomatic LTCF residents who have received COVID-19 vaccination in the prior 3 days:

- Pending evaluation, these **residents should be restricted to their current room or placed in a single person room** (if available) and cared for by healthcare personnel wearing all PPE recommended for residents with suspected or confirmed SARS-CoV-2 infection. They should **not** be cohorted with residents with confirmed SARS-CoV-2 infection **unless** they are also confirmed to have SARS-CoV-2 infection through testing.
- Criteria for when Transmission-Based Precautions may be discontinued depend on the results of the evaluation. If the resident's symptoms resolve within 2 days, precautions can be discontinued. Fever, if present, should have resolved for at least 24 hours before discontinuing precautions.
- Consider viral testing for SARS-CoV-2 if symptoms do not improve or persist for longer than 2 days.

COVID-19 Associated Deaths

Case Definition:

A novel coronavirus-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be COVID-19 by an appropriate laboratory test. There should be no period of complete recovery between the date of COVID-19 diagnosis and the date of death.

A death should **NOT** be reported if any of the following are true:

1. There is no laboratory or other diagnostic confirmation of SARS-CoV-2 virus infection
2. Novel coronavirus illness is followed by full recovery to baseline health status prior to death
3. After review and consultation there is an alternative agreed upon cause of death

Laboratory testing for SARS-CoV-2 infection can be from pre- or post-mortem clinical specimens.

Guidance for implementation of COVID-19 associated deaths case definition:

1. This is a SURVEILLANCE case definition, not a medical definition.
2. A death certificate is NOT needed. Under North Carolina's current surveillance case definition, it is possible both for someone to meet the case definition to be counted as a COVID-19 associated death and not have COVID-19 listed on the death certificate, and for someone to have COVID-19 on their death certificate and not be counted as a COVID-19 death. The determination of whether a case is a COVID-19 associated death for surveillance purposes is a public health decision, while the causes of death on the death certificate is the determination of the physician or medical examiner.



- a. COVID-19 does not have to be a direct cause of death for a death to be COVID-19 associated. The key question is: would this person have died at this time if they had not had COVID-19? Or did COVID-19 in some way hasten their death? If they might have lived longer, then it is a COVID-19 associated death.
- b. If the decedent was mentally or physically incapacitated and unable to be interviewed or if the interview (prior to death) was questionable, then symptoms of COVID are difficult to determine. This should be counted as a death unless there was another non-COVID-19 cause of death (e.g. trauma).
3. If you determine a case is not a COVID-19 death, documentation should be provided in the notes or the discharge summary or death report can be attached to the event if they are available.

NC COVID Demo – Updating Deaths

Demo on editing COVID-19 associated deaths is attached to the email accompanying the weekly key points.

Case Investigation/Contact Tracing Updates

Contacts will soon be able to flow directly from NC COVID to CCTO via a single-entry process in NC COVID. Case investigators will be able to enter contacts via Question Package #10: Contact Tracing in NC COVID, and these contacts will flow automatically into CCTO on a regular basis. Contacts who flow into CCTO through this process will not be assigned to users but instead assigned to teams by county, and therefore, someone from each county will need to check the view for *My Team's Active Contacts* to reassign these contacts. Expected implementation date is late December.

Digital exposure notification capabilities within CCTO for contacts are now live. Contacts receive a text or email from CCTO as their initial notification that they have been exposed. The notifications also direct the recipient to a specific web page where they can fill out an assessment and access helpful resources. **NOTE:** Each LHD has the option to adopt and use digital exposure notification, either as an enhancement to existing contact tracing or as single notification of exposure, based on NC DHHS prioritization guidance. There is no requirement to implement these features.

We are also developing capabilities to send positive cases a digital notification via text or email. This notification will direct cases to a specific web page where they can find links to guidance, resources, and other support services. Expected implementation date is early January.

State Laboratory of Public Health Update

- SARS-CoV-2 diagnostic RT-PCR assays are qualitative, not quantitative, and are not designed to determine the amount of virus present in the specimen (viral load) because many external factors can influence these results.
- There are many variables that impact cycle threshold (Ct) value that are unrelated to the amount of viral RNA in a specimen such as proper (or improper) specimen collection or transport.



- The amount of virus present in a person can vary during the course of their illness. A specimen may have a higher Ct value (low viral load) if the patient is early in their infection and the virus is still increasing in their body or later in infection when the viral load is decreasing. In both of these examples the high Ct still represents a true positive with SARS-CoV-2 nucleic acid detected.
- Regardless, for SARS-CoV-2, it is still unknown how much virus is needed to transmit virus from person to person and cause new infections. This is one of the many areas of ongoing research.

The Interpreting Diagnostic Test Results FAQ on the [CDC Website](#) answers several pertinent questions related to cycle threshold and testing.

The Association of Public Health Laboratories guidance document on cycle threshold is located here:

<https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-COVID19-Ct-Values.pdf>

Find My Testing Place

Please review the updated 'Find My Testing Place LHD' Excel file weekly to ensure information is up to date and accurate. Please send the updated files or any related questions to SVC_Covid-19TestingSites@dhhs.nc.gov